

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E641		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/15/2013	
NAME OF PROVIDER OR SUPPLIER ROYAL TERRACE NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 201 E FLAMING RD OLATHE, KS 66061			
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F 000	INITIAL COMMENTS			F 000			
F 272 SS=D	<p>The following citations represent the findings of a Non-Compliance Revisit.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p>			F 272			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: The facility reported a census of 55 residents and the sample included 5. Based on observation, record review, and interview, the facility failed to complete a comprehensive assessment regarding nutrition for 1 (#104) resident in the sample.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #104's significant change Minimum Data Set (MDS) 3.0 dated 1/17/13 recorded long and short term memory problems, able to recall she/he was in a nursing home, and was moderately impaired with decision making skills. The resident required extensive assistance of two staff with bed mobility and transfers, total dependence of one staff with locomotion on/off unit, and required extensive assistance of one staff with dressing, eating, toilet use, and personal hygiene. The resident had a swallowing disorder and difficulty or pain with swallowing, received a mechanically altered/therapeutic diet, and had no natural or tooth fragments. <p>The Care Area Assessment (CAA) dated 1/29/13 for nutrition recorded the resident received a pureed diet with nectar thickened liquids only when alert, sat upright while eating, and ate in the assisted dining room. Nursing staff or the hospice aide assisted the resident with eating, weight loss</p>			F 272			

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F 272	<p>Continued From page 2</p> <p>was expected and anticipated due to the end of life status.</p> <p>An observation on 1/6/13 at 9:37 A.M. revealed the resident sat in a wheelchair at the nursing station; licensed nursing staff I provided the resident with 150 cubic centimeters (cc) of Med Pass, nutritional supplement, mixed with chocolate syrup and one Magic Cup, nutritional supplement. Staff assisted the resident with feeding. The resident did not attend the morning meal in the dining room.</p> <p>During an interview on 2/12/13 at 10:41 A.M. with administrative nursing staff E revealed he/she completed CAAs during any comprehensive assessment period which included resident admission, significant change and annual assessments. He/she obtained information required for completion of the CAAs from the resident's medical record and nursing staff interviews.</p> <p>The facility failed to address the causative factors regarding the resident's nutrition on the Care Area Assessment for this resident.</p>			F 272			
F 279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive</p>			F 279			

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F 279	<p>Continued From page 3 assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: The facility reported a census of 55 residents and the sample included 5. Based on observation, record review, and interviews, the facility failed to develop comprehensive and individualized care plans for 5 (#101, #102, #103, #104, and #105) residents in the sample.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident # 101's quarterly Minimum Data Set (MDS) 3.0 dated 11/20/12 recorded long and short term memory problems, severely impaired decision making skills, had continuous inattention and disorganized thinking, hallucinations, and physical behaviors directed towards others and other behavior symptoms not directed towards others. The resident required extensive assist of two staff with bed mobility, transfers, walking in room/corridor, locomotion on the unit, dressing, eating, toilet use and personal hygiene. <p>The Care Area Assessment (CAA) dated 3/9/12 for nutrition recorded the resident triggered for</p>			F 279			

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F 279	<p>Continued From page 4</p> <p>significant change MDS due to hospice status. Resident showed significant weight loss in the last 30 days due to a decline in health with need for hospice care.</p> <p>The care plan dated 7/24/12 and reviewed 11/29/12 for comfort care related to end stage disease process documented the resident was a "do not resuscitate" and received hospice care with interventions which included: the nursing staff to assess for pain and provide pain relief measure medications as ordered by physician and/or used distraction to alleviate the resident's pain, the staff positioned the resident for comfort and provided exercise. The nursing staff to provide the resident soothing touch, opportunity for socialization, one on one interaction as needed, private time with family and/or significant others. Hospice care to provide care by a licensed hospice provider.</p> <p>An observation on 2/5/13 at 3:43 P.M. revealed the resident rested bed with his/her eyes closed.</p> <p>During an interview on 2/7/13 at 2:12 P.M., administrative nursing staff E and corporate consultant II reported nursing staff or administrative nursing staff reviewed resident care plans quarterly.</p> <p>Review of the policy/procedure for care plans dated 03/12 revealed "A Comprehensive Care Plan must be developed by the interdisciplinary Care Planning Team within seven days after completion of the comprehensive assessment (MDS)."</p> <p>The facility failed to develop and individualize the</p>			F 279			

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F 279	<p>Continued From page 5</p> <p>care plan for the coordination of care between the facility and the licensed hospice provider for this cognitively impaired resident.</p> <p>- Resident #102's quarterly Minimum Data Set (MDS) 3.0 dated 11/26/12 recorded a Brief Interview for Mental Status (BIMS) score of 9 which indicated mild cognitive impairment and displayed rejection of care. The resident required limited assist of one staff with bed mobility, transfers, dressing, toilet use and personal hygiene, supervision and set up with locomotion on/off unit and eating, and used a wheelchair.</p> <p>The Care Area Assessment (CAA) dated 9/14/12 for nutritional status documented the resident received a regular, no concentrated sweet diet, was noncompliant with his/her diet, and refused dietary recommendations. The resident's weight was stable and fluid intake was adequate at this time.</p> <p>A care plan dated 7/25/12 and reviewed 2/3/13 for nutritional risk related to gastroesophageal reflux (backflow of stomach contents to the esophagus), therapeutic diet with intake below 75 percent (%), resident desired weight loss, diagnosis of diabetes mellitus, morbid obesity, hypothyroidism (condition characterized by decreased activity of the thyroid gland), and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and listed the following interventions: the resident received diet as ordered by physician while staff honored food preferences; nursing staff to monitor the resident's weight, laboratory tests,</p>			F 279			

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F 279	<p>Continued From page 6</p> <p>food intake and encourage the resident's fluid intake. The care plan updated on 7/26/12 for the nursing staff to encourage the resident to lose weight and follow the diet, the resident sometimes refused breakfast, wanted to lose weight and preferred to sleep late in the morning. On 9/5/12 staff updated the care plan to include the resident ate items from the snack machine and on 9/12/12 documented the nursing staff to administer medications as ordered by the physician. On 2/3/13 the care plan update included the nursing staff to administer protein supplement and diuretic (medication to promote the formation and excretion of urine) as ordered by the physician and to notify the physician if the staff observed signs or symptoms of dehydration.</p> <p>An observation on 1/6/13 at 11:29 A.M. revealed the resident sat in a wheelchair in the dining room and at 11:45 A.M. the resident received turkey pot roast, mashed potatoes with gravy, carrots, dinner roll, and brownie. The resident salted the food independently and consumed 100% of the meal, the resident requested a bowl of soup and consumed 75% of the soup.</p> <p>During an interview on 2/7/13 at 2:12 P.M., administrative nursing staff E and corporate consultant II reported nursing staff or administrative nursing staff reviewed resident care plans quarterly.</p> <p>Review of the policy/procedure for care plans dated 03/12 revealed "The Care Planning Coordinator is to review the 24-hour report daily for significant changes or changes in resident's ADL status. The Care Planning coordinator will add minor changes in resident's status to the</p>			F 279			

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F 279	<p>Continued From page 7 existing care plans on a daily basis."</p> <p>The facility failed to individualize the care plan for the type of diet and supplements, weight monitoring schedule, medications received, labs ordered, and food preferences of this resident.</p> <p>- Resident #103's annual Minimum Data Set (MDS) 3.0 dated 12/10/12 recorded a Brief Interview for Mental Status (BIMS) score of 9 which indicated mild cognitive impairment and disorganized thinking fluctuated. The resident required extensive assist of one staff with bed mobility, dressing, and personal hygiene; limited assist of one staff with transfers, walking in room /corridor, locomotion on/off unit, eating, and extensive assist of two staff with toilet use. The resident was not steady, only able to stabilize with staff assist with turning around while walking and moving on/off toilet, was only able to stabilize without staff assist with moving from seated to standing position, walking, and surface to surface transfer, used a walker and had no impairment in range of motion (ROM) in upper/lower extremities.</p> <p>The Care Area Assessments (CAA)s dated 12/10/12 for Activities of Daily Living (ADL) function recorded the resident used a walker for mobility. He/she needed one staff assist with toileting, transferring to toilet, and changing of his/her incontinence product. The facility admitted the resident from the hospital after he/she was found on the floor at home. The resident had an unsteady gait; used a walker for mobility, had impaired decision making skills with a diagnosis of dementia, (progressive mental disorder</p>	F 279					

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F 279	<p>Continued From page 8</p> <p>characterized by failing memory and confusion), and required one staff assist with ambulation.</p> <p>The quarterly data collection tool dated 12/10/12 recorded a score of 11 indicating the resident was at risk for falls and used a repositioning bar on the bed.</p> <p>The care plan dated 10/18/12 recorded the resident was at risk for alteration in skin due to frequent incontinence of urine and required assistance with bed mobility. The care plan directed staff to provide a pressure reducing device on the resident's bed, refer the resident to the dietician to evaluate the resident's nutritional status, and offer supplemental nutrition support as ordered. The care plan recorded an update dated 2/5/13 for the resident to use a positioning rail to assist with repositioning while in bed.</p> <p>Frequent observations of the resident's room on 2/5/13 and 2/6/13 revealed bilateral upper positioning rails on the resident's bed.</p> <p>During an interview on 2/6/13 at 4:44 P.M., licensed nursing staff H reported the staff assessed the residents for the need for repositioning bars upon admission and quarterly thereafter by the nursing staff.</p> <p>During an interview on 2/7/13 at 2:12 P.M., administrative nursing staff E and corporate consultant II reported nursing staff or administrative nursing staff reviewed resident care plans quarterly.</p> <p>Review of the policy/procedure for care plans dated 03/12 revealed "The Care Planning</p>			F 279			

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F 279	<p>Continued From page 9</p> <p>Coordinator is to review the 24-hour report daily for significant changes or changes in resident's ADL status. The Care Planning coordinator will add minor changes in resident's status to the existing care plans on a daily basis."</p> <p>The facility failed to individualize the resident care plan to included the use of repositioning bars on the resident's bed.</p> <p>- Resident #104's significant change Minimum Data Set (MDS) 3.0 dated 1/17/13 recorded long and short term memory problems, able to recall she/he was in a nursing home, and was moderately impaired with decision making cognitive skills. The resident required extensive assistance of two staff with bed mobility and transfers, total dependence of one staff with locomotion on/off unit, required extensive assistance of one staff with dressing, eating, toilet use, and personal hygiene, had a swallowing disorder and difficulty or pain with swallowing, received a mechanically altered/therapeutic diet, and had no natural or tooth fragments.</p> <p>The Care Area Assessment (CAA) dated 1/29/13 for nutrition recorded when the resident was alert he/she received a pureed diet with nectar thickened liquids, sat upright while eating, and ate in the assisted dining room. Nursing staff or the hospice aide assisted the resident with eating, weight loss was expected and anticipated due to the end of life status.</p> <p>The care plan dated 2/3/13 for weight loss noted for staff to expect weight loss due to hospice decline. Interventions included: a nutritional risk</p>			F 279			

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F 279	<p>Continued From page 10</p> <p>assessment to be completed by the dietitian, the facility to review resident's food likes/dislikes (likes sweet, chips, soda), the facility to provide dietary supplements as appropriate (Magic Cup and Med Pass with chocolate syrup added), the facility staff to assure food consistency was appropriate (built up silverware and divided plate with all meals), the facility staff to monitor meal consumption for each meal and offer food substitute with less than 75 percent intake; and inquire if there was something special the resident wanted to eat when appropriate.</p> <p>An observation on 1/6/13 at 9:37 A.M. revealed the resident sat in a wheelchair at the nursing station, licensed nursing staff I provided the resident with 150 cubic centimeters (cc) of Med Pass mixed with chocolate syrup and one Magic Cup. Staff assisted the resident with feeding. The resident did not attend the morning meal in the dining room.</p> <p>During an interview on 2/7/13 at 2:12 P.M., administrative nursing staff E and corporate consultant II reported nursing staff or administrative nursing staff reviewed resident care plans quarterly.</p> <p>Review of the policy/procedure for care plans dated 03/12 revealed "A Comprehensive Care Plan must be developed by the interdisciplinary Care Planning Team within seven days after completion of the comprehensive assessment (MDS)."</p> <p>The facility failed to develop an individualized care plan for nutrition for this resident.</p>			F 279			

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F 279	<p>Continued From page 11</p> <p>- Resident #105's significant change Minimum Data Set (MDS) 3.0 dated 12/28/12 recorded a Brief Interview for Mental Status (BIMS) score of 15 which indicated he/she was cognitively intact. The resident required supervision of one staff with bed mobility, dressing, and toilet use, limited assistance of one staff with transfers, locomotion on/off unit, and personal hygiene, and supervision and set up with walking in room/corridor and eating.</p> <p>The Care Area Assessment (CAA) dated 1/1/13 for nutritional status recorded the resident's discharge weight on 11/26/12 was 120 pounds (#), readmission weight was 112 #, and the staff currently weighed the resident weekly. The CAA triggered for nutrition due to the resident's need of a therapeutic diet of no added salt (NAS) diet and weight loss. The dietician visited the resident routinely and he/she had no chewing or swallowing issues.</p> <p>The care plan dated 1/15/13 for nutritional risk related to the diagnosis of diabetes mellitus (a group of metabolic diseases in which a person has high blood sugar) listed interventions: staff to serve the resident a regular diet and supplements as physician ordered, and the nursing staff were to monitor the resident's weight.</p> <p>A Physician's Order dated 1/1/13 documented a new order for a Magic Cup (dietary supplement) and on 1/6/13 the physician discontinued the Magic Cups.</p> <p>An observation on 1/6/13 at 7:39 A.M., revealed the resident sat in the dining room and consumed</p>			F 279			

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F 279	Continued From page 12 100 percent of oatmeal, scrambled eggs, cranberry juice, coffee, and one slice of toast; and he/she fed self. During an interview on 2/7/13 at 2:12 P.M., administrative nursing staff E and corporate consultant II reported nursing staff or administrative nursing staff reviewed resident care plans quarterly. Review of the policy/procedure for care plans dated 03/12 revealed "A Comprehensive Care Plan must be developed by the Interdisciplinary Care Planning Team within seven days after completion of the comprehensive assessment (MDS)."			F 279			
F 281 SS=D	The facility failed to individualize the care plan for nutrition and weight monitoring for this resident. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: The facility reported a census of 55 residents and the sample included 5. Based on observation, record review, and staff interview, the facility failed to follow signed physician orders for 1 (#101) resident of the sample. Findings included: - Resident #101's quarterly Minimum Data Set (MDS) 3.0 dated 11/20/12 recorded long and			F 281			

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F 281	<p>Continued From page 13</p> <p>short term memory problems, severely impaired decision making skills, had continuous inattention and disorganized thinking, hallucinations, and physical behaviors directed towards others and other behavior symptoms not directed towards others. The resident required extensive assist of two staff with bed mobility, transfers, walking in room/corridor, locomotion on the unit, dressing, eating, toilet use and personal hygiene. The resident was not steady and only able to stabilize with staff assistance, used a wheelchair, and received antipsychotic and antianxiety medications seven days per week.</p> <p>The Care Area Assessment dated 3/9/12 for nutrition documented the resident triggered for a significant change related to hospice status. The resident showed significant weight loss for thirty days due to a decline in the resident's health which required hospice services. He/she ate a mechanical soft diet and the diet was liberalized from a no added salt (NAS) diet to a regular diet to promote/encourage the resident's oral intake.</p> <p>The care plan dated 7/24/12 and last reviewed 11/29/12 for nutritional risk related to chewing, swallowing, and behavioral problems psychosis (any major mental disorder characterized by a gross impairment in reality testing), diabetes (a group of metabolic diseases in which a person has high blood sugar), dementia (a progressive mental disorder characterized by failing memory and confusion), failure to thrive (includes not doing well, feeling poorly, weight loss, poor self care that can be seen in elderly individuals), history of weight loss, and continued decline/gradual weight loss expected the following approaches: the facility to provide the</p>			F 281			

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F 281	<p>Continued From page 14</p> <p>resident a pureed diet with honey thickened liquids, the staff to monitor weights weekly, labs as ordered and to record food intake, the staff to honor the resident's food preferences as applicable, speech therapy to screen and treat the resident if indicated, gastrointestinal consult if indicated, the staff to assess and/or monitor the resident for constipation, the staff to encourage the resident to consume fluids, the staff to provide the resident frequent rest periods and assess the resident for causes of decreased oral intake. The staff to provide total assist to resident with meals and a high calorie snack at 10 A.M. and 2 P.M., fortified cereal with breakfast, and supplements as ordered, and hospice care and services to the resident.</p> <p>A Dietary Progress Note dated 12/5/12 documented the resident decreased in weight by 5 pounds in one month (4.5 percent (%) decrease), decreased in weight by 5 pounds in 3 months (5.1% decrease), and decreased by weight by 5 pounds in 6 months (4.9% decrease). The resident received a diet pureed with honey thickened liquids, the staff fed the resident and the resident "usually eats well per nursing". The staff provided the resident a Magic Cup (nutritional supplement) at 10 A.M. to help minimize weight loss. The resident's weight was discussed with nursing and the dietician made the recommendation for the staff to weigh the resident weekly, provide super cereal with breakfast, and continue to encourage the resident to consume food and fluids. In addition, the facility to increase Magic Cup (nutritional supplement) to two times daily.</p> <p>A signed physician's order dated 12/6/12</p>			F 281			

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F 281	<p>Continued From page 15</p> <p>recorded "increase Magic Cup" to two times daily.</p> <p>The signed Physician's Order Sheet (POS) for January 2013 dated 1/3/13 and February 2013 dated 1/31/13 recorded Magic Cup three times a day.</p> <p>Review of the January and February 1-7 2013 Medication Administration Record revealed the resident received the Magic Cup two times a day.</p> <p>An observation on 2/6/13 at 5:30 P.M. revealed the resident sat in a straight back chair in the dining room and required total assist of one staff with eating. The resident held food in his/her mouth at times and the staff provided verbal prompting for the resident to swallow the food in his/her mouth.</p> <p>During an interview on 2/7/13 at 9:00 A.M., dietary manager DD reported the dietary manager or cook reviewed the diet orders for accuracy. He/she acknowledged the signed POS for January 2013 dated 1/3/13 stated for the facility to provide Magic Cup three times daily.</p> <p>The facility failed to provide the nutritional supplement as ordered by the physician for this cognitively impaired, dependent resident with weight loss.</p>			F 281			
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment</p>			F 309			

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F 309	<p>Continued From page 16 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: The facility reported a census of 55 residents and the sample included 5. Based on observation, record review, and staff interview, the facility failed to assess, provide treatment for and monitor ecchymosis, bruising, for 1 (#101) resident of the sample.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #101's quarterly Minimum Data Set (MDS) 3.0 dated 11/20/12 recorded long and short term memory problems, severely impaired decision making skills, had continuous inattention and disorganized thinking, hallucinations, and physical behaviors directed towards others and other behavior symptoms not directed towards others. The resident required extensive assist of two staff with bed mobility, transfers, walking in room/corridor, locomotion on the unit, dressing, eating, toilet use and personal hygiene. The resident was not steady and only able to stabilize with staff assistance, used a wheelchair, and received antipsychotic and antianxiety medications seven days per week. <p>The Care Area Assessment (CAA) dated 3/9/12 for falls recorded the resident was previously ambulatory on the special care unit, and currently had impaired balance and the resident was unable to stand or ambulate without staff assist. The resident was at risk for falls due to dementia (a progressive mental disorder characterized by</p>			F 309			

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F 309	<p>Continued From page 17</p> <p>failing memory and confusion), psychosis (any major mental disorder characterized by a gross impairment in reality testing), short and long term memory impairment, and impulsivity (displaying behavior characterized by little or no forethought). Bed and chair alarms were utilized, the resident's bed was placed in the lowest position when occupied, and nursing staff placed a fall mat on the floor beside the resident's bed.</p> <p>The care plan reviewed on 11/29/12 recorded the resident was at risk for falls related to a fall risk score greater than 10, impaired cognitive status, unsteady gait, and a history of falls, directed staff to complete a fall risk assessment upon admission and quarterly thereafter; to assess the resident's ability to comprehend and follow directions; to provide visual reminders to the resident; to assure clear pathways, proper fitting shoes, ambulate resident when the resident became restless and adequate lighting in the resident's room. The staff placed the call light within the resident's reach or keep the resident in an area where staff could monitor. The staff were not to leave the resident unattended in the restroom, staff used bed and chair alarms for the resident, and staff placed a perimeter mattress on the bed and while the resident in bed, the bed to be in the lowest position. The resident sat in a low broda paddle rocker (specialized wheelchair).</p> <p>A fall investigation witness statement recorded on 2/1/13 at 11:25 A.M. the resident sat in the Broda chair in the living room. The resident stood unattended, fell to the floor, and landed on his/her right side and hit his/her head on the floor. Further documentation recorded initially no injuries were noted, no change to the resident's</p>			F 309			

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F 309	<p>Continued From page 18</p> <p>range of motion in extremities, with redness noted to the resident's right cheek and shoulder area at a later time.</p> <p>The fall investigation report dated 2/1/13 recorded no resident injuries with the follow up recommendation for a medication review of the resident's medications.</p> <p>A fall investigation report dated 2/5/13 record the resident's bed alarm sounded, upon entering the resident's room the staff witnessed the resident laid on the floor next to the heater. The investigation recorded the resident was not injured. The report further documented the recommendation of staff to assist the resident out of bed when the resident was not asleep.</p> <p>An observation on 2/8/13 at 5:00 P.M. revealed the resident seated in a Broda chair in the living room with a yellowish ecchymotic (bruised) area noted on his/her right cheek approximately the size of a baseball.</p> <p>Review of the clinical record lacked documentation of the ecchymotic area on the resident's right cheek.</p> <p>During an interview on 2/7/13 at 2:12 P.M., administrative nursing staff D reported he/she documented only significant injuries on the fall investigation reports, he/she did not record bruising.</p> <p>During a meeting on 2/7/13 at approximately 5:45 P.M. administrative staff D reported it was his/her expectation that staff would document bruises noted on a resident in the nursing notes section</p>			F 309			

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F 309	Continued From page 19 of the medical record. Review of the policy/procedure for falls committee dated 03/12 revealed following a resident fall the staff would assess the resident for injury and treat the resident. The facility failed to assess the the resident for and monitor this cognitively impaired, dependent resident for bruising after the resident had two recent falls.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: The facility reported a census of 55 residents and the sample included 5. Based on observation, record review, and staff interview, the facility failed to develop and implement measures for the prevention of pressure ulcers for 1 (#103) resident of the sample. Findings included: - Resident #103's annual Minimum Data Set (MDS) 3.0 dated 12/10/12 recorded a Brief	F 314			

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F 314	<p>Continued From page 20</p> <p>Interview for Mental Status (BIMS) score of 9 which indicated mild cognitive impairment and disorganized thinking fluctuated. The resident required extensive assist of one staff with bed mobility, dressing, and personal hygiene, limited assist of one staff with transfers, walking in room/corridor, locomotion on/off unit, eating, and extensive assist of two staff with toilet use. The resident was not steady, only able to stabilize with staff assist with turning around while walking and moving on/off toilet, only able to stabilize without staff assist with moving from seated to standing position, walking, and surface to surface transfer, used a walker and had no impairment in range of motion (ROM) in upper/lower extremities.</p> <p>The Care Area Assessments (CAA)s dated 12/10/12 for Activities of Daily Living (ADL) function recorded the resident used a walker for mobility. He/she needed one staff assist with toileting, transferring to the toilet, and changing of his/her incontinence product; and for falls recorded the facility admitted the resident from the hospital following an admission after he/she was found on the floor at home. The resident had an unsteady gait, used a walker for mobility, had impaired decision making skills with a diagnosis of dementia, (progressive mental disorder characterized by failing memory and confusion) and required one staff assist with ambulation.</p> <p>The Care Area Assessment (CAA)s dated 12/10/12 for Pressure Ulcers recorded the resident used a walker for locomotion. He/she was incontinent and the staff was to provide peri-care after each of resident's incontinent episodes. The staff was to assess the resident</p>			F 314			

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F 314	<p>Continued From page 21</p> <p>weekly for skin issues and to perform a Braden (scale used to predict pressure ulcers) assessment of the resident on a quarterly basis.</p> <p>The care plan dated 10/18/12 for alterations in skin related to the resident's frequent incontinence of urine and required staff assist with bed mobility listed the following approaches: the facility provided a pressure reducing device on the resident's bed, the staff referred to dietician for evaluation of resident's nutritional status and monitored the resident's skin weekly and during showers. A care plan revision dated 1/28/13 directed the staff to cleanse the resident's second toe of the right foot, apply skin prep and cover the area with tape daily and on 2/5/13 recorded the resident had a Stage II pressure ulcer on the second toe of the right foot.</p> <p>Review of the December 2012 and January 2013 Treatment Administration Records (TAR) revealed a treatment initiated on 12/29/12 noted "Duoderm [dressing] cut to fit second right great toe, change every 3 days" and it was discontinued on 1/28/13.</p> <p>An unsigned physician order dated 1/28/13 recorded "cleanse second toe right foot area with normal saline, apply skin prep, cover with tape, change every day".</p> <p>A Pressure Ulcer Record documented on 1/28/13 a Stage II pressure ulcer first observed on 1/28/13 on the second toe of the resident's right foot measured 0.5 centimeters (cm) by 0.2 cm, without odor or drainage.</p> <p>Review of the Weekly Wound Assessment Sheet</p>			F 314			

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F 314	<p>Continued From page 22</p> <p>dated 1/2/13 recorded the staff noted "redness" on the resident's second toe of his/her right foot, the area remained unchanged on 1/8/13, 1/16/13, and 1/23/13 with no treatment recorded.</p> <p>An observation on 2/5/13 at 4:38 P.M. revealed the resident sat in a chair located in his/her room, the resident wore socks with velcro strap shoes, the right shoe with the top cut out sat on the footstool beside the resident's chair.</p> <p>An observation on 2/6/13 at 6:00 P.M. revealed the resident ambulated from the dining room with a front wheeled walker and one staff assist. The resident's shoe had the top cut out.</p> <p>During an interview on 2/6/13 at 10:30 A.M., during observation of the dressing change, licensed nursing staff I reported the resident had a hammer toe (a deformity of the toe) on the second toe, right foot. He/she reported staff cut the top of the resident's shoe out to accommodate the hammer toe and the staff encouraged the resident to remove the shoe when not ambulating.</p> <p>During an interview on 2/7/13 at 12:57 P.M., direct care staff P reported the resident had an open area on his/her right toe and the resident could wear shoes whenever he/she desired.</p> <p>The facility failed to develop interventions to prevent the development of pressure ulcers on the foot for this cognitively impaired resident with a deformity of the toe.</p>			F 314			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES			F 323			

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F 323	<p>Continued From page 23</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: The facility reported a census of 55 residents and the sample included 5. Based on observation, record review, resident and staff interview, the facility failed to implement preventative measures care panned to prevent falls for 1 (#101) and failed to ensure the environment was free of hazards for 1 (#102) resident of the sample.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #101's quarterly Minimum Data Set (MDS) 3.0 dated 11/20/12 recorded long and short term memory problems, severely impaired decision making skills, had continuous inattention and disorganized thinking, hallucinations, and physical behaviors directed towards others and other behavior symptoms not directed towards others. The resident required extensive assist of two staff with bed mobility, transfers, walking in room/corridor, locomotion on the unit, dressing, eating, toilet use and personal hygiene. The resident was not steady and only able to stabilize with staff assistance, used a wheelchair, and received antipsychotic and antianxiety medications seven days per week. 			F 323			

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F 323	<p>Continued From page 24</p> <p>The Care Area Assessment (CAA) dated 3/9/12 for falls recorded the resident was previously ambulatory on the special care unit, currently had impaired balance and the resident was unable to stand or ambulate without staff assist. The resident was at risk for falls due to dementia (a progressive mental disorder characterized by failing memory and confusion), psychosis (any major mental disorder characterized by a gross impairment in reality testing), short and long term memory impairment, and impulsivity (displaying behavior characterized by little or no forethought). Interventions included bed and charm alarms, the resident's bed in the lowest position when occupied, and nursing staff placed a fall mat on the floor beside the resident's bed.</p> <p>The care plan reviewed on 11/29/12 recorded the resident was at risk for falls related to a fall risk score greater than 10, impaired cognitive status, unsteady gait, and a history of falls, and directed staff to complete a fall risk assessment upon admission and quarterly thereafter, to assess the resident's ability to comprehend and follow directions, to provide visual reminders to the resident, to assure clear pathways, proper fitting shoes, ambulate resident when the resident became restless and adequate lighting in the resident's room. The staff to place the call bell within the resident's reach or keep the resident in an area where staff could monitor. The staff would not leave the resident unattended in the restroom, place bed and chair alarms appropriately, and the bed with a perimeter mattress placed in the lowest position while occupied. The resident sat in a low Broda paddle rocker (specialized wheelchair).</p>			F 323			

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F 323	<p>Continued From page 25</p> <p>A fall investigation witness statement recorded on 2/1/13 at 11:25 A.M. the resident sat in the Broda chair in the living room. The resident stood unattended, fell to the floor, and landed on his/her right side and hit his/her head on the floor. Further documentation recorded initially, the staff noted no injuries, no change to the resident's extremity range of motion, with redness noted to the resident's right cheek and shoulder area at a later time.</p> <p>The fall investigation report dated 2/1/13 recorded no resident injuries with the follow up recommendation for a medication review of the resident's medications.</p> <p>Staff updated the care plan on 2/1/13 with the recommendation to review the resident's medication.</p> <p>A fall investigation report dated 2/5/13 recorded the resident's bed alarm sounded, upon entering the resident's room the staff witnessed the resident laid on the floor next to the heater. The investigation recorded the resident was not injured. The report further documented the recommendation of staff to assist the resident out of bed when the resident was not asleep.</p> <p>The staff updated the care plan for falls on 2/5/13 to include for staff to place floor mats on both sides of the bed and assist the resident out of bed when not asleep.</p> <p>Multiple observations on 2/6/13 and 2/7/13 revealed the resident rested in his/her bed, and the bilateral fall mats were not on the floor beside the resident's bed.</p>			F 323			

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F 323	<p>Continued From page 26</p> <p>An interview on 2/7/13 at 2:36 P.M. administrative nursing staff D reported the facility stored floor mats in the central supply storage area and it was his/her expectation for the nursing staff to obtain equipment from central supply at the time of intervention initiation.</p> <p>An interview on 2/7/13 at 2:47 P.M. administrative nursing staff D reported nursing staff updated resident care plans daily with any new physician orders and the resident care plans were reviewed daily by administrative nursing staff during the facility staff morning meetings. He/she reported the facility completed a Fall Investigation for root cause report within 24 hours of a resident fall to determine the cause of the fall and to develop interventions based upon cause of fall.</p> <p>Review of the facility policy/procedure dated 03/12 for Falls Committee recorded "staff meeting to determine cause", and establish and implement interventions on plan of care after each fall.</p> <p>The facility failed to have bilateral floor mats in place as care planned for this resident with frequent falls.</p> <p>- Resident #102's quarterly Minimum Data Set (MDS) 3.0 dated 11/26/12 recorded a Brief Interview for Mental Status (BIMS) score of 9 which indicated mild cognitive impairment, and the resident displayed rejection of care. The resident required limited assist of one staff with bed mobility, transfers, dressing, toilet use and</p>			F 323			

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F 323	<p>Continued From page 27</p> <p>personal hygiene, supervision and set up with locomotion on/off unit and eating, and used a wheelchair.</p> <p>The Care Area Assessment (CAA) dated 9/14/12 for falls recorded the resident continued to be at risk for falls related to an unsteady gait. He/she used a walker to ambulate short distances but the resident becomes tired and his/her legs become weak, a wheelchair was used for long distances, and therapy services to evaluate gait and strengthening.</p> <p>The care plan dated 12/2/12 for risk for falls related to resident's noncompliance with therapy recommendations, walked in his/her room, had unsteady gait, and had previous falls at another facility listed approaches of: the resident was independent in his/her daily routine, the staff to educate the resident to lock his/her wheelchair brakes when transferring, the resident received restorative nursing and therapy services as ordered, nursing staff to complete fall assessments quarterly, the resident to wear rubber soled shoes when up in his/her wheelchair, and the staff was to provide a clear uncluttered pathway in the resident's room and hallway, and a perimeter mattress placed to the resident's bed.</p> <p>An observation on 2/6/13 at 9:15 A.M. revealed the resident slept in bed with one 1/4 rail in the up position on the right side of the bed and an approximate 3-4 inch gap between the side rail and the mattress.</p> <p>An interview on 2/7/13 at 12:57 P.M. direct care staff P reported it was the responsibility of all staff</p>			F 323			

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F 323	Continued From page 28 to make sure the mattress fit the bed frame properly. An interview on 2/7/13 at 2:47 P.M. administrative nursing staff D reported maintenance and nursing as a team ensured the resident's mattress was properly placed on the bed frame. An interview on 2/7/13 circa 5:30 P.M. administrative nursing staff D stated staff placed the perimeter mattress on a different bed frame during the facility remodeling process. The facility failed to ensure this cognitively impaired resident's side rail fit the bed appropriately.			F 323			
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the			F 520			

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F 520	<p>Continued From page 29 requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 55 residents. Based on observation, record review, and staff interview, the Quality Assessment and Assurance (QAA) committee failed to identify and remedy issues that required an action plan.</p> <p>Findings included:</p> <p>- On a facility re-visit survey conducted 2/5/13, 2/6/13, and 2/7/13:</p> <p>The facility failed to ensure the QAA committee addressed the completion of a comprehensive assessments for one resident. Please refer to F272.</p> <p>The facility failed to ensure the QAA committee addressed development of a comprehensive care plan for five residents. Please refer to F279.</p> <p>The facility failed to ensure the QAA committee addressed implementation of physician orders for one resident. Please refer to F281.</p> <p>The facility failed to ensure the QAA committee addressed assessment after a fall for one resident. Please refer to F309.</p> <p>The facility failed to ensure the QAA committee</p>	F 520					

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F 520	<p>Continued From page 30</p> <p>addressed development of interventions to prevent the development of pressure ulcers for one resident. Please refer to F314</p> <p>The facility failed to ensure the QAA committee implemented preventative measures developed to ensure a safe environment for two residents. Please refer to F323.</p> <p>The facility failed to have an effective Quality Assessment and Assurance program in place to monitor and implement corrective actions for issues identified.</p>			F 520			